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ABSTRACT

Discussed are issues in screening children for potential learning disabilities at the nursery school level. Definitions and incidence estimates of learning disabilities are evaluated, and present screening programs are reviewed. Three teacher administered screening tests are described: Peabody Picture Vocabulary Test, Beery Developmental Test of Visual Motor Coordination, and Caldwell Preschool Inventory. A child study is given in which a 3-year-old child suspected of having a learning disability turned out to be at high risk because of lack of opportunity to develop personal social skills. Strongly recommended are the reviewing of test manuals before undertaking a screening project; gaining the cooperation of parents in remediation of and home management techniques; increasing cooperation among pediatricians, schools, and parents; and encouraging teachers to grow professionally. (DB)

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A SCHOOL PSYCHOLOGIST'S PERCEPTIONS OF LEARNING DISABILITIES IN THREE-YEAR-OLD CHILDREN IN AN EARLY CHILDHOOD CENTER

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INTRODUCTION

Many nursery schools were first created under the Works Progress Administration. During World War II, day care centers were established and Project Head Start gave added impetus to the nursery school movement. In 1965 President Johnson announced a project to include the development of a year-round program for children three to five years of age which has given further significance to the interest in the young child.

As we have expanded our interest in the preschooler, so too have we expanded our knowledge of his growth and development. This has led to our present efficiency in current identification measures. As we use these instruments we begin to evaluate them and their efficiency in detecting problems of early childhood. This has led us to an involvement in problems of measurement, definition, and even the kinds of services that are now offered to meet the needs of children in whom various handicapping conditions are found. However, it has become increasing obvious to educators that the identification of disabilities in young children needs a variety of approaches from pediatrics and education together. No where is this more obvious than in the field of learning disabilities today.

Thus, learning disabilities has become an area of major concern to all educators. Until quite recently, children presenting problems in learning and adjustment were categorized primarily as being mentally retarded, sensorially impaired, or emotionally disturbed. As we have become more aware that there are other children who defy classification, we have attempted to find a more appropriate and meaningful label for such youngsters. Thus, developed the term learning disability.

Some experts claim that learning disability afflicts as few children as one to three percent of the school-age population. Other experts claim the incidence to be as high as 30 percent. Obviously, such difference in estimates reflect a real disagreement as to what constitutes a learning disability. In attempting to explain away the problems of so many of our children who appear to be failing in school, it is possible that we have gone too far in the opposite direction. Learning disability has now become a catch-all term for any condition which involves unexplainable failure in school.

In an attempt to deal directly with such issues surrounding learning disabilities, Illinois is presently involved in a project called SCREEN. With funds provided through a legislative appropriation, the Office of the Superintendent of Public Instruction contracted for a thorough study of learning disabilities in Illinois. In addition, OSPI supported the development of a mechanism by which Illinois schools can identify children with impediments to learning and school adjustment prior to the damaging and complicating effects of failure in the primary grades.

There can be no doubt that project SCREEN will contribute a great deal towards discovering more about learning disabilities in the early primary level. The question that concerns us here today is: What can be done about learning disabilities in the preschool child. Indeed, is there such a thing as the learning disabled preschooler?

Mykelbust in his book, Progress in Learning Disabilities, defines learning disabilities in this way:

> "It consists of a deficiency in learning despite adequate intelligence, hearing, vision, motor capacity, and emotional adjustment. These children differ (especially from the mentally retarded) in that normal capacity for learning exists, and in that normal outcome is anticipated."

Dr. William M. Cruickshank points out that in the current literature there are more than 40 English terms which are used that essentially apply to the same child. This issue of differences in terminology is itself confusing. Professor Cruickshank argues for a modification to the term specific learning disabilities.

In relation to the preschool child, I am advocating that we drop the term learning disability altogether. If we feel we must label the preschooler, I would offer the term "high risk." It seems important to avoid long-range predictions in regard to categorizing and labeling the child and his functioning in the future. It is unfair both to the child and to his parents. This is true because what appears to be a learning disability to the untrained or inexperienced person may in actuality be a developmental lag.

Studies in the current literature indicate that despite the interest in learning disabilities and the unquestioned presence of individual children with such serious developmental discrepancies, evidence for the existence of a sizable subgroup of children who can be so labeled at the preschool level is still surprisingly meager. It is a mysterious category with a shortage of evidence as to how many such children there are, what the developmental processes of the disabilities are, and what can be done about those so categorized.

It is also difficult, if not impossible, to label a preschooler learning disabled in the nursery school setting because generally children do not appear to have learning disabilities until they enter the primary grades. Usually the youngster's difficulties aren't apparent until he starts reading and writing. When the intelligent child begins to fail at these tasks, becomes frustrated, and acts out, we begin to suspect a learning problem.

Dr. Gofman and Dr. Allmond in their publication, Current Problems in Pediatrics, point out that seeking an etiologic description of learning-disabled children is unproductive and useless. They advocate the formulation of a child's profile of function because it can more readily be translated into a program of remediation and treatment for any and all disciplines involved. A profile of function, in the authors' view, relinquishes labels and specific diagnosis in favor of descriptive statements that answer the question: What are the strengths and weaknesses a specific child brings with him into the learning situation? Such a profile would take into consideration the preschooler's temperament, environmental background, and learning style.

R. Reed Zehrbach points out the fact that there is a difference between screening and diagnosis. He states that "too frequently, screening--a quick, tentative check--is confused with diagnosis--the thorough, complex examination. Screening, in this discussion, refers to assessment techniques which are used to determine whether a child exhibits sufficient deficiencies which suggest a need for a thorough evaluation by a trained, certified professional. Diagnosis refers to the final opinion as to whether or not a specific intervention is needed such as program modification, remediation or special placement.

In reviewing existing screening techniques, Senf and Comrey considered many procedures deficient because of one or more of the following reasons.

1) Many assessment techniques for preschoolers rely on either teachers' referrals or on formal testing methods. This fails to combine the valuable and unique information which each technique can offer.

2) Most existing tests need to be administered individually. Usually this requires a certified or highly trained examiner. (This would seem to make screening desirable only in the wealthiest of communities).

3) Many screening instruments have a diagnostic orientation which labels the preschooler.

4) Screening programs comprised of a variety of existing tests require that the information be combined intuitively. This increases the possibility for subjective bias and can be done only by personnel with a high level of training.

5) Most readiness tests attempt to assess the whole range of functioning rather than focusing on high-risk pupils.

6) Test materials rather than assessment services are provided, thereby placing additional burdens on the schools to organize their own testing programs and on teachers to score and interpret the results.

7) Most procedures provide only normative scores without interpreting their meaning to the classroom teacher in understandable language.

8) The few available group-administered tests are complex for young pupils resulting in difficult administration and in scores of questionable significance.

9) Screening procedures comprised of panels of professionals are expensive, cumbersome, and frequently indecisive by virtue of insufficient information or varying professional orientation.

How does the educator go about setting up a profile of function for identifying the preschoolers who may be high risk in view of all the difficulties Senf and Comrey indicate? It is my view that a group of teachers and consultants meet together and decide on the particular needs of the children in their setting. They can attempt to minimize some of the problems associated with screening by being aware of the difficulties involved and by planning in advance for the possible uses to which the results can be applied. If the attempt of the assessment is not to label the nursery school child but to provide remediation and intervention, teachers could more readily be involved in the planning, implementation and disposition of the outcomes of the testing program.

Because of the large numbers of preschoolers now entering school, the testing movement has made it necessary that scales become more and more simplified in their administration and scoring so that tests need no longer be given only by qualified examiners. This shift in emphasis of test administration has focused on the classroom teacher as being the person best suited to examining the young child. Generally the teacher is the person who knows the youngster best at school, and she will also be the one who will first identify problem areas in the child's life, and ultimately have to deal with any difficulties on a daily basis.

In keeping with the philosophy that the tests used must be teacher administered, rough screening for this project was assessed by three instruments: (1) Peabody Picture Vocabulary Test (PPVT) (2) Beery's Developmental Test of Visual-Motor Coordination (3) Caldwell's Preschool Inventory.

Peabody Picture Vocabulary Test

This test yields a measure of receptive language in three forms: mental age (MA), intelligence quotient (IQ), and percentile ranking. Only the mental age was used in reporting results as it was felt there might be a great deal of controversy in listing an IQ on the child's records as well as in interpreting it to the parents. Children scoring significantly low, that is, six months or more below chronological age, were referred to the speech and language therapist for follow-up screening and recommendations. (Bi-lingual children were not included in this screening).

Developmental Test of Visual-Motor Integration

This test includes the copying of simple geometric forms which become progressively harder. There is a short form available for preschoolers and younger children. Generally, interpretations of the child's score on this test were lenient. As long as a three-year-old was able to make a vertical line, and some kind of circular motion, he was not considered high risk. If the child was over 3-6 and could not experience success on the first three designs of the VMI, he was considered a candidate for follow-up testing in six months. In the interim, the results were reported to all the teachers who might be working with the child and remediation was begun as recommended in Beery's Manual of the VMI.

Caldwell's Preschool Inventory

This measure was used to check on the youngster's knowledge of his immediate environment. This inventory was the measure most preferred by teachers because it gave them back the most valuable information to begin with in the school setting. Thus, areas of difficulty could be easily identified and the teacher could attempt to work on building such skills as recognizing colors, nameing body parts, repeating first and last name, etc.

Referral to the psychologist was recommended if the child showed significant deficits in the three tests utilized. A child was also considered eligible for evaluation by the psychologist after six weeks in the setting if he appeared to be experiencing problems which hampered his development. Examples of this were the children who could be not be separated from their mothers, cried continuously, appeared unusually active,

were excessively aggressive, regressed in toilet habits, etc. The psychologist's position at this point was to administer a Denver Developmental Screening Test to identify specific problem areas. The Denver studies four areas of functioning in the child s life space: personal-social, fine-motor adaptive, language, and gross-motor. A full psychological was administered only if the teachers, parents and psychologist together felt there was a reason to establish the child's intellectual functioning. Often, the child was referred back to his primary physician for further study to rule out difficulties with suspected hearing and vision problems, awkward motor coordination, hyperactivity, etc.

The following is a case study of a three-year-old boy who was referred for more in-depth study to the psychologist. This case was chosen because the preschooler tested significantly low on two measures, the Peabody Picture Vocabulary Test and the Visual-Motor Integration Test. Teachers suspected, therefore, that this little boy might have a learning disability in the areas of speech and visual-motor integration. As it turned out, in-depth evaluation revealed that this youngster, Ben Smith, was actually at high risk because of lack of opportunity to develop appropriately in personal-social skills in the home environment.

CHILD STUDY: LEARNING DISABLED OR HIGH RISK?

Name: Ben Smith
Birthdate: 9-1-72

Reason for referral: 1) Low test scores on PPVT and VMI
2) Child could not be separated from his mother in the nursery school setting
3) Speech appears immature and there are problems with gross motor coordination (gait awkward, stumbles frequently)

Background Information:

This three-year-old boy is the only son of middle-age professional parents. His medical history indicates birth was normal. Developmental pattern was somewhat slow; that is, this boy did not begin repeating words until two and one-half years of age. Hearing and vision have been checked and are normal.

Behavioral Impressions and Observations at the Time of Testing:

Because Ben could not be separated from his mother, Mrs. Smith remained in the testing situation on two separate occasions. At first Ben did not want to leave the security of his mother's lap. However, when the examiner placed some toys on the table out of his reach, he eventually climbed down to inspect a toy telephone and some stacking blocks of different shapes. Ben was observed to use toys appropriately and constructively. He sorted circles, squares and triangles in their proper spaces very quickly. He pretended to talk on the telephone and handed his mother the phone in an effort to engage her in a play conversation. At the end of the first interview, Ben was offered a sucker. Mrs. Smith immediately volunteered that Ben would be unable to remove the wrapper from the candy. The examiner suggested that Ben be allowed to try unwrapping the sucker on this occasion in order to determine whether he could not or would not be

able to do what was requested of him. When the candy was offered again, Ben fingered the sucker briefly, then held it up to his mother for her to open. When Mrs. Smith did not respond, Ben began to cry and make whining noises. At this, mother unwrapped the candy, saying, "See, this goes on all the time at home." She hurried to explain that she and her husband are not "pushy" parents and are waiting until Ben is able to do some things by himself.

At the second interview, Ben was again offered a sucker upon leaving. When Ben attempted to elicit his mother's aid, Mrs. Smith started to help him; however, she hesitated, glancing at me as if for advice. Again, I suggested she allow Ben to try unwrapping the candy. Following this suggestion, mother said to Ben, "You try this time by yourself. We know you can do it." With a great deal of patience, and effort, Ben was able to unwrap the candy. It was felt that mother needs a great deal of support to enable her to encourage her son's developmental growth.

Tests Administered:

Stanford-Binet Intelligence Scale, Form L-M (Revised): CA 3-0
MA 3-2

Denver Developmental Screening Test: Definite lag noted in personal-social area.

Vineland Social Maturity Scale: Findings suggest Ben is functioning at about an 18 month level in personal-social skills.

Discussion of Test Results:

Ben is a sturdy, well-built little boy was was 3-0 at the time of the evaluation. On the first visit, he was cooperative, although somewhat wary. On his second visit, he apparently decided he was going to like the attention and games I was ready to provide and he appeared to be a warm, appealing and engaging child. His attention was well-sustained

throughout the examination. Ben correctly answered all items at Year II-6 on the Binet. At the Year III level, he was unable to do the three tests involving visual-motor ability: building a bridge, copying a circle and drawing a vertical line. While Ben's speech was somewhat unintelligible at times, much of what he said could be understood with careful listening. He did best on items involving vocabulary and verbal fluency. For example, he succeeded with responses to pictures at the Year III-6 level and he passed vocabulary at the Year III level. The overall impression is that he is functioning in the average range of intellectual functioning, with potential for doing somewhat better.

During the administration of the Vineland Social Maturity Scale with the mother, it became evident that Ben is having great difficulty in social skills. Mother reported he cannot pull off his socks unless they are over the heels. He eats only finger foods, and he was only taken off baby foods at 21 months. Mother spoon feeds Ben at this time because "he won't use a spoon himself." Presently, he crawls up and down stairs. He wears diapers at night. Ben cannot wash his hands unassisted. The mother's greatest concern was the fact that Ben does not play with other kids; that is, he is not even engaging in parallel play. He started nursery school about 6 weeks ago, but has been unable so far to separate from his mother.

The Denver Developmental Screening Test verified that there is a definite lag in personal-social areas. Ben was unable to perform any tasks at chronological age expectancy.

Summary

This little boy was seen for evaluation because of low test scores on screening instruments. His speech was also somewhat slow in developing.

He has not been able to easily separated from the mother in the nursery school setting. Present test findings indicate Ben is functioning in the average range of intelligence with potential for doing somewhat better. Vocabulary and verbal fluency are at chronological level. It must be pointed out, however, that these tests measured expressive speech and receptive language may be somewhat lower. While speech was somewhat unintelligible at times, much of what Ben said could be understood. This appears to be a great gain in view of the fact that he only started in the past six months, according to mother's report.

A real area of concern at this time is seen as this little boy's lag in personal-social skills. It was only through careful questioning, that it could be ascertained from his mother that while Ben is able to do some tasks in self-care areas, he is resisting. Mother pointed out, for example, Ben does not use a spoon. When a spoon was presented to Ben and he was asked by the examiner to show what he should do with it, he was able to lift it to his mouth and pretend to eat. The child is also crawling up and down stairs because mother feels this is a safer way for him to get around the house. When it was suggested Ben should be allowed to use stairs with the aid of a railing, mother became defensive and said, "He'll do it when he's ready." It was felt that this boy's difficulties may be reinforced by his mother who does not reinforce appropriate growth patterns in her son's development.

Recommendations

1) Alter school schedule to two half-days per week.
2) Speech therapist feels this boy would profit from limited help and would be available when Ben is in school half-days.
3) Parents need help with home managing techniques. Psychologist to meet with family bi-monthly to plan with mother.
4) Counseling will be suggested to mother.

What implications are suggested by screening for learning disabilities in the three and four-year-old child?

1) Before undertaking a screening project, school staff should review test manuals with particular attention being paid to the standardization sample.

2) Parents must be willing to cooperate with the school in remediation and home management techniques if the child is identified as high risk.

3) There must be greater cooperation between pediatricians, schools, and parents.

4) Teachers must be willing to grow professionally.

Review Test Manuals and Standardization Sample

In studying the standardization sample for the Visual-Motor Integration Test by Keith Beery it was learned that eighteen boys and ten girls, or a total of 38 three-year-old children were administered the VMI as part of the standardization sample. All three-year-old youngsters were representative of the suburban group; thus, there were no three-year-olds from either the rural or lower middle-class groups included in the sample. It would appear, therefore, that this test must be used cautiously in interpreting profiles of three-year-olds. Buros in the Seventh Mental Measurements Yearbook states the case much more strongly: "It seems unlikely that the test is of much use with children below four years of age."

Unless professionals familiarize themselves with the manual before undertaking a screening project, they may find that the test is not the most reliable instrument to detect deficiencies for particular groups.

Parents Must Be Willing to Cooperate with the School and Staff

Much of the child's behavior and a great deal of what he learns is influenced by the attitudes of the parents as well as the environment of the home. Parents who are defective in communicating appropriate attitudes or in fostering adequate development in their children must be willing to learn new management techniques if these are necessary in helping the preschooler. Primarily, this means that the mother must be helped if she is, in turn, to help her child. We now recognize that the early mother-child relationships are the most important in molding a child's personality and adjustment. Later on, the broad general features of the home environment and parental attitudes will be incorporated by the child and, hence, assume greater importance the older the child becomes.

Ira Gordon points out when parents are actively involved in the education of their children, they will continue to enhance the child's growth and their own activity after the formal program ends. Early childhood education recognizes the need for parents to be involved in the education of their youngsters. Baratz and Baratz state this involvement should occur at all level of program development. Parents who take an active role in the process of educating their children, may actually enhance their own self concept and personal image. Often parents of children from low income levels are labeled as lacking adequate child rearing skills and as a result present a poor model for children to emulate. Thus, the final recommendation must be a shift away from the almost sole dependency on the school setting to administer to the cognitive needs of young children toward a truly collaborative home-school

relationship.

There Must Be Greater Cooperation between Pediatricians, Schools, and Parents

As we undertake an assessment program for the high risk child, we find that many of the youngster's problems are related to his physical development, medical status, and emotional attitude as well as his readiness to learn. This means that there must be input from many disciplines if our primary focus is on school readiness rather than school failure. Professionals must be willing to communicate to each other regarding their findings and recommendations about the child so that the preschooler may be approached with an understanding of his total functioning rather than a "piece meal" view of what might be wrong with him. This would allow parents the opportunity to see how the disciplines are cooperating together in helping the child and avoid one of the common difficulties we see in clinics and testing centers today--the parents who go from one place to another, one professional to another seeking answers to the questions: What is wrong with my child? How can I help him?

Teachers Must be Willing to Grow Professionally

The teacher's commitment to preschool education is a crucial variable in determining the success of the program. As a professional, she must be willing to take on more professional goals. Educators must also be willing to admit that each person is both a teacher and a student throughout life. As a student, the professional teacher goes on learning.

SUMMARY

This paper has attempted to convey the idea that labeling the

preschooler is not as important as identifying his areas of deficit and providing intervention for him. Every child in an intervention program should begin at his own level of development and proceed from there at a pace in keeping with his own individual growth. That goal can only be obtained if: 1) There is adequate information available as to what knowledge the child brings with him to the program 2) Curriculum is available that can be adapted to the preschooler's needs 3) Concerned adults are available to pace the level of the child's instruction. Presumably, all these conditions can be met be a committed teacher.

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